

Registration District No. 3/2

Primary Registration District No. 6057

1. PLACE OF DEATH:

(a) County **St. Clair**  
(b) City or town **Osceola Rural**  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution:  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution **59 years** (Specify whether years, months or days)  
In this community

3. (a) PRINT **Sarah Cathrine Inskeep**  
FULL NAME

3. (b) If veteran, **No** 3. (c) Social Security No. **No**

4. Sex **Female** 5. Color **White** 6. (a) Single, widowed, married, divorced **Married**  
(b) Name of husband or wife **Robert Inskeep** 6. (c) Age of husband or wife if alive **70**  
7. Birth date of deceased **February 27 1876**  
(Month) (Day) (Year)

8. AGE: **67** Years **7** Months **25** Days If less than one day hr. min.

9. Birthplace **Green County Ind**  
(City, town, or county) (State or foreign country)

10. Usual occupation **Housekeeping**

11. Industry or business

12. Name **William H. Howard**  
13. Birthplace **Dayton Ohio**  
(City, town, or county) (State or foreign country)  
14. Maiden name **Cathrine Allen**  
15. Birthplace **Iowa**  
(City, town, or county) (State or foreign country)

16. (a) Informant **Robert Inskeep**  
(b) Address **Osceola Missouri**

17. (a) **Burial** (b) Date thereof **10-29-43**  
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Kidds Chapel**

18. (a) Signature of funeral director **Osceola Funeral Home**  
(b) Address **Osceola Missouri**

19. (a) **Oct-26-43** (b) **E. E. Loh, Missie Traylor**  
(Date received local registrar) (Registrar's signature) Deputy

2. USUAL RESIDENCE OF DECEASED:

(a) State **Missouri** (b) County **St.**  
(c) City or town **Osceola Rural**  
(If outside city or town limits, write "RURAL")  
(d) Street No. (If rural, give location)  
(e) Citizen of foreign country? **No** (Yes or No)  
If yes, name country

MEDICAL CERTIFICATION

**October 24**

20. DATE OF DEATH: **1943** Month **12** day **20** minute **209** M.

21. I hereby certify that I attended the deceased from **3-20-43** to **10-24-43**  
that I last saw him alive on **9-22-43**  
and that death occurred on the date and hour stated above.

Immediate cause of death **Coronary Thrombosis**

Due to **Hypertension**

Due to **Diabetes**

Other conditions (Include pregnancy within 3 months of death) **61**

Major findings: Of operations

Of autopsy

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)  
(b) Date of occurrence  
(c) Where did injury occur? (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

(Specify type of place) While at work? (c) Means of injury

23. Signature **T. H. Dargatzis** (M. D. or other) **m.d.**  
Address **Osceola, Mo.** Date signed **10-26-43**

RECEIVED

District Health Officer No: 7;

District File Number

Date Filed

10-43-1204

11-8-43

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by

, Registered Apprentice No.

working under my personal supervision.

Signed

Paul Truistone

Licensed Embalmer No.

3990

P. O. Address.

Osceola, Mo.

**Note:** The above **MUST BE SIGNED BY THE LICENSED EMBALMER** in his **OWN HANDWRITING**. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.